



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HEALTHCARE
4301 VISTA ROAD
PASADENA TX 77504-2117

Respondent Name

TPCIGA FOR FREMONT INDEMNITY CO

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-03-1659-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All TWCC-required documentation has been submitted to Carrier. In addition, additional documentation was not requested within 14 days of receipt of medical bill."

Amount in Dispute: \$4,444.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on 12/2/2002. Carrier maintains its position as outlined in the original response. It does not appear that Requestor properly requested reconsideration as it did not indicate the reasons why requestor believed its position was correct. In addition, the RFR did not reference the original EOBs."

Response Submitted by: FOL, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2001	ASC Services	\$4,444.76	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 TexReg 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor

Code §413.011(d)], until such period that specific fee guidelines are established by the commission.

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 2, 2002. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, the Division notified the requestor on December 9, 2002 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - N-Not appropriately documented.

Findings

1. 28 Texas Administrative Code §§133.307(g)(3)(B), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "All TWCC-required documentation has been submitted to Carrier. In addition, additional documentation was not requested within 14 days of receipt of medical bill."
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
 - The requestor does not discuss or explain how the documentation supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	5/31/2012 _____ Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.